



# Local Child Safeguarding Practice Review Practitioner Briefing

## Child F – exploitation risks & adultification in safeguarding teenagers

### WHO SHOULD READ THE BRIEFING?

Any practitioner and manager whose work brings them into contact with children, young people, adults and their families. For further information on our safeguarding review visit the Dudley safeguarding website.

### HOW WE DID THE REVIEW/CASE BACKGROUND

Child F, a teenager, was considered at risk of criminal exploitation. A significant incident triggered a LCSPR referral and rapid review. During the period of focus Child F was open to Children's Services on a child protection plan before becoming a Child Looked After on a Section 20 basis. Child F was open to DMBC's Children Services Exploitation Team and had significant Police and Youth Justice involvement, Child F's mother had involvement from services for mental health and substance misuse.

The Partnership agreed further lessons could be learnt from this case, with the aim of better safeguarding the children of Dudley. The review process involved review of case information and meetings with professionals to discuss the case and learning for the wider system. Throughout the process the views of both Child F and Child F's mother were sought – the voice of both individuals are captured in the [full report](#).

It is acknowledged that the Covid-19 pandemic was a significant context for the vast majority of the time period this review focused on. The review focused on learning that can be applied in 'normal' operating conditions (rather than Covid-19 specific).

### OVERVIEW OF LEARNING

A summary of learning identified during the review.

- **Information sharing and communication**

The mother of Child F said her number one message to all services was to think more meaningfully about communication. This was not aimed at one particular agency, but was her general comment on the lack of perceived effort made to help people experiencing services understand what is happening and why.

'Tell me face to face not in a letter', and 'give me the reasons' was her clear message.

- **Relationship building and professional curiosity around potential safeguarding concerns**

Relationship building should be key to all practice – there is evidence of agencies trying consistently to support the family, trying different approaches and there were periods of progress. However the family describe inconsistency in 'genuine interest'. While some professionals tried to build relationships, they often leave meaning the family have to start again. Leading to a sense of resistance noted by some agencies in relation to engagement with professionals.

Professional curiosity, exploring the lived experience of individuals in a meaningful way to encourage disclosure and engagement.

- **Recognising exploitation risks**

Agencies did coordinate information to try to map and understand Child F's lived experience, but analysis in the rapid review highlights the complexity of mapping and planning when there is a risk of exploitation and absence of firm information from the family as to what is happening.

The review explored with professionals the expectation for professional curiosity around potential exploitation. There is DSPP activity and awareness raising around exploitation and contextual safeguarding.

- **The potential relevance of 'adultification' in safeguarding teenagers**

*'The concept of adultification is when notions of innocence and vulnerability are not afforded to certain children. This is determined by people and institutions who hold power over them. When adultification occurs outside of the home it is always founded within discrimination and bias'<sup>1</sup>.*

Use of language, consideration of experienced trauma, exposure to adult conversation at an inappropriate age, not proactively considering support for transitions, following appropriate child policies and putting appropriate plans in place are all themes of adultification.

- **Think family approach in relation to safeguarding, contextual risk and lived experience of a child.**

The review found little conscious consideration of culture and ethnicity in the provision of services or the understanding of experiences for Child F.

The review identified that think family means different things to organisations. Unless there was a specific direct safeguarding risk services working with adults in the family focused on the person in their service, rather than the potential implications or experiences on the children. There was little evidence of conversations between child and adult services to support exploration or understanding of how diagnosed conditions for mother and child impacted on their behaviour and interactions with each other, or the impact of both their conditions on the lived experience of other siblings. Likewise there was little exploration into the multiple elements of substance misuse within the same family or what the barriers for attendance at appointments were.

- **Identifying young carers**

It was recognised by professionals that Child F's mother was struggling to cope, with responsibilities falling on her children to help around the house and care for each other, yet there was no evidence of professionals actively considering whether the children might be young carers.

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<sup>1</sup> David and Marsh (2020) <https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2022/06/Academic-Insights-Adultification-bias-within-child-protection-and-safeguarding.pdf>

## RECOMMENDATIONS

1. Agencies working with adults and/or children to provide assurance to DSPP that they have effective joint working practices when working with members of the same family. Within their practice there is a need to recognise how the needs of each person in the family affect each other and to respond appropriately to this need.
2. DSPP to revisit the multi-agency training content to incorporate 'adulthood' into appropriate courses to raise awareness of this concept. This may assist in helping practitioners to understand how this can relate to practice and professional curiosity.
3. The Partnership should strengthen communications to ensure that Professionals in Dudley are aware of their responsibilities in identifying and ensuring that there is assessment of young carers. The impact of this communication campaign should be monitored.

## MORE INFORMATION

The full LCPSR report can be accessed [here](#)

DSPP [Thematic Learning from Case Reviews- Exploitation Awareness](#) provides further information and links to resources.

Further information is available via the [DSPP Child Exploitation Webpage](#)

[Child Exploitation Process Flowchart](#)

[Child Exploitation Screening Tool](#)

[Support Level Guidance and Framework](#)

[Partnership Information Sharing \(FIB\) Form](#)

[Guidance for Partnership Information Sharing \(FIB\) Form](#)

[Guidance for professionals when discussing and recording work with exploitation](#)

DSPP learning resources linked to this review:

[Safer 7 - Adulthood](#)

[Safer 7- Think Family](#)

[Safer 7 – Exploitation in Dudley](#)

[Safer 7- Trauma Informed Practice](#)

[Safer 7 – Information Sharing](#)

[Safer 7 – Vicarious Trauma](#)

[Safer 7 – Professional Curiosity](#)

Information on the Partnership's training offer is available via the [Learning Zone](#)